QUALITY ASSURANCE AND IMPROVEMENT

TECHNICAL ASSISTANCE CONFERENCE CALL

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Arranged by:

Division of HIV Services
Bureau of Health Resources Development
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EXECUTIVE SUMMARY

This report summarizes information presented in "Quality Assurance and Improvement," the sixth in a series of nationally broadcast technical assistance telephone conference (teleconference) calls arranged by the Division of HIV Services (DHS), Health Resources and Services Administration (HRSA). It is important to note that this summary reflect both the content of the presentations and comments from listeners during the call. The teleconference call was broadcast on August 3, 1995, and over 700 people in 146 sites participated nationwide.

The purpose of the teleconference call was to address approaches for achieving and maintaining quality in HIV-related service delivery funded through the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. Discussion focused on three levels of quality assurance: (1) internal evaluation of planning councils and consortia, (2) evaluation of funded service providers, and (3) quality improvement emphasizing improvement of client care.

Quality improvement can be defined as *a broad spectrum of evaluation and intervention activities designed to improve the quality of health care and support services.*

HRSA considers it extremely important that CARE Act funds be used both efficiently and effectively, resulting in the delivery of the highest possible quality of care to all clients. HRSA also recognizes the challenges which HIV care programs and providers face in focusing on quality of care because of the need to emphasize other issues related to establishing structures, processes, and a system of HIV/AIDS care in their communities. DHS will work with Title I and Title II grantees, planning bodies, providers, and clients to strengthen and structure evaluation and quality improvement as an integral part of CARE Act efforts. A variety of HIV-related quality of care issues have been addressed through previously published clinical practice guidelines. DHS believes that these guidelines need to be integrated into HIV care programs to the greatest extent possible. Standards related to social support services are also an important part of quality assurance and improvement. New requirements related to quality assurance and improvements are expected in the legislation reauthorizing the CARE Act.

Evaluating the performance of a planning council or consortium requires a review of three things in order to assess efficiency and effectiveness -- *structure*, the *process* through which work is done, and *outcomes*. Seven self-assessment modules are now being prepared by DHS to help planning councils and consortia evaluate performance related to legislatively mandated functions and program responsibilities.

Evaluation of provider performance should always be done "relative to their contract." Quality of care standards for providers must be contractual to be enforceable, so these must be included in the Requests for Proposal (RFP) process and in contract documents.

Service provider evaluation in rural areas and evaluation of small agencies offer special challenges, as do issues of confidentiality and cultural competence.

Quality improvement activities are designed to show "good stewardship" of the funds provided. Health care providers and professionals have a responsibility to evaluate themselves, and to include client and community input. HIV/AIDS providers should be asked and should ask themselves whether they are making good use of the funds provided and whether they are in fact improving the health status or quality of life of people with HIV disease and their families. Quality Improvement Programs can include internal and external components, and can cover both clinical and social support services. Models used in New York State, North Carolina, and Orange County, California demonstrate structures and processes for setting and applying standards and implementing programs contributing to ongoing improvements in the quality of care provided to persons with HIV disease and AIDS and their families.

The teleconference call contributed to what HRSA expects will be a long-term collaborative process. The continuing participation of planning councils and consortia, grantees, providers, clinicians, clients, and other community representatives is necessary to help identify and take additional steps towards the goal of assuring high quality care for people living with HIV disease and AIDS throughout the country.

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I. INTRODUCTION

A. PURPOSE

This report summarizes the information presented in "Quality Assurance and Improvement," one of a series of nationally broadcast technical assistance telephone conference (teleconference) calls arranged by the Division of HIV Services (DHS), Health Resources and Services Administration (HRSA). It is important to note that this summary reflect both the content of the presentations and comments from listeners during the call. The teleconference call was broadcast on August 3, 1995.

The purpose of the teleconference call was to address approaches for achieving and maintaining quality in HIV-related service delivery funded through the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. It focused on three levels of quality assurance:

- Internal evaluation of planning councils and consortia;
- Evaluation of funded service providers; and
- Quality improvement, emphasizing improvement of client care.

The hour-long teleconference included panelists from the DHS and from planning councils, consortia, and Title I and II grantees. (See Appendix A for a list of panelists, with contact information and Appendix B for the agenda.) The appendices provide sample materials provided by one of the panelists, as well as some additional selected readings (See Appendices C and D).

B. PROCESS

Like the other teleconference calls in this series, the teleconference addressed topics and questions submitted by Title I and Title II grantees, consortium and planning council members, and CARE Act-funded providers. In addition, listeners had an opportunity to ask questions during the call. Over 700 people from around the country participated in the teleconference call.

II. QUALITY IMPROVEMENT CONCEPTS AND EXPECTATIONS

A. TERMINOLOGY

Panelists used a variety of terms related to quality improvement. As used in the teleconference call, most of the terms referred to methods of evaluating and improving the quality of services provided to clients. DHS described quality improvement as:

> ***...a broad spectrum of evaluation and intervention activities designed to improve the quality of health care and support services.***

The terms *quality improvement* and *quality assurance* were described in materials provided by two grantees:

- The Orange County HIV Planning Advisory Council defines quality improvement as *activities and programs designed to evaluate client care* and to *identify, study, correct, and document known or suspected problems in, or opportunities to improve, client care.* A Quality Improvement Plan is designed to *monitor, evaluate, and improve client services and programs* and *ensure optimal provision of client services and programs.*

- The AIDS Care Branch within the Department of Environment, Health and Natural Resources in North Carolina uses a Quality Assurance Peer Review process for case management. This is defined as a process *designed to provide service providers the opportunity to evaluate the quality* of services being provided, *identify problems, recommend solutions, and help develop strategies for strengthening* these services.

- Quality assurance and improvement for CARE Act programs include *accountability for process, outcomes, and impact* related to both planning councils and consortia and funded service providers.

B. HRSA'S EXPECTATIONS

HRSA recognizes that it has not been easy for HIV care programs and providers to focus on quality of care because of the need to emphasize other responsibilities, such as establishing effective planning bodies, increasing representation and diversity, getting funds obligated for service provision, carrying out comprehensive planning, and establishing a system of care. However, because of the importance of meeting the changing needs associated with the epidemic, taking advantage of clinical advances, and coping with finite resources, DHS

emphasizes the importance of assuring that funds are expended both efficiently and effectively, with the delivery of the highest possible quality of care.

Within the Public Health Service (PHS), a variety of HIV-related quality of care issues have been addressed through previously published clinical practice guidelines. DHS believes that these guidelines need to be integrated into HIV care programs to the greatest possible extent.

A recent 1995 report by the Office of the Inspector General (OIG) found some limits in local evaluation efforts, and recommended that:

- Best practices should be disseminated and shared; and

- Grantees should be responsible for evaluating their programs.

The current status and quality of evaluation and quality improvement efforts are largely unknown. DHS is supporting the development of a series of seven self-assessment modules for use by Title I and Title II grantees in evaluating their activities (See Section III of this report). A recent survey found that about half of Title I eligible metropolitan areas (EMAs) are doing formal evaluation in at least one of the seven areas covered by the self-assessment modules. However, more information is needed so that DHS can help develop and promote effective strategies to assist grantees and providers to improve the quality of care in their programs.

DHS is participating in a HRSA-wide HIV Quality Improvement Project whose goal is to help determine the current level of quality improvement in CARE Act programs. It includes several phases:

- **Phase One: to identify quality improvement activities and organize references for possible dissemination in the future.** Plans are being made to ask CARE Act grantees to provide existing materials developed or adapted for use in improving quality of care, such as data collection instruments related to patient satisfaction, client outcomes, and medical chart review; protocols and descriptions of quality improvement activities; practice guidelines; performance measures; and standards of care.

- **Phase Two: to hold a "think tank" meeting to share information and models and address key issues related to quality improvement, and develop some specific recommendations to strengthen quality improvement efforts.** The meeting will involve grantees, clinicians, providers, people living with HIV (PLWHs), planning council and consortium members, and HRSA staff.

C. REAUTHORIZATION LEGISLATION REQUIREMENTS
(As of August 31, 1995)

New requirements related to quality assurance and improvement are expected in the reauthorization legislation for Ryan White, and will probably affect in many different sections of the new Act. A Senate reauthorization bill has been passed, and action in the House is likely after the summer recess. For example, the new legislation may include the following:

- Additional requirements for planning council assessment of the administrative mechanism, in terms of the effectiveness of services offered in meeting identified needs, plus costs and outcome effectiveness of services to the extent that data are reasonably available.

- Identification of specific service priorities within both Titles I and II, such as services to pregnant women to prevent the perinatal transmission of HIV.

- Inclusion of quality assurance, quality control, and related activities within a cost cap for both Titles of 12.5% on subcontract and administrative costs on the Senate side, or a 10% administrative cap for both Titles on the House side.

- Establishment of a minimum recommended formulary of FDA-approved drugs, including drugs for prevention of opportunistic infections and prevention of active TB.

DHS expects to establish a collaborative process with grantees to incorporate legislative changes into guidances and program implementation over a transitional period.

III. INTERNAL EVALUATION OF PLANNING COUNCILS AND CONSORTIA

A. WAYS TO EVALUATE PERFORMANCE

Evaluating the performance of a planning council or consortium is one step in evaluating the overall quality of HIV/AIDS programs in a service area. The planning council or consortium is responsible for doing a needs assessment, developing a community-wide service plan, and often selecting service providers to implement the plan. To evaluate their performance requires a review of three different things in order to assess efficiency and effectiveness -- (1) structure, (2) the process through which work is done, and (3) outcomes. Evaluation means judging the merit of something by comparing it to a "yardstick" known as standards of measurement or criteria:

- **Efficiency** can be measured using criteria related to how the planning body is structured and operated -- how meetings are run, members' understanding of the mission, the working relationships among member agencies, etc.

- **Effectiveness** can be measured by using criteria related to outcomes or products -- the effectiveness of your needs assessment, implementation of your strategic plan, duplication of services, etc.

The first step in evaluation is to develop a set of goals and objectives including measurements or standards. For example:

- If one structural goal is to have a planning body membership that reflects the racial and ethnic diversity of the community, one objective and standard might be to have **45% of planning body membership be African American**, if 45% of the infected community was African American.

- If one outcome goal is provision of services which accurately reflect the need in your community, one objective might be to do a needs assessment which produces enough accurate information to assist in decisions about which services are needed. An outcome measure might be **95% client utilization of services**, determined by measuring year-end client utilization data against needs assessment priorities.

The box which follows provides a recommended evaluation process for use by planning councils and consortia.

AN EIGHT-STEP EVALUATION PROCESS

1. Establish an evaluation committee.
2. Have that committee develop goals, objectives, and standards.
3. Have the planning council or consortium membership review and approve those goals, objectives, and standards.
4. Establish procedures for the evaluation, including specification of evaluation methods and instruments.
5. Determine any constraints and resistances and develop a plan to overcome them.
6. Develop an evaluation schedule.
7. Implement the plan.
8. Distribute and use the information acquired through the evaluation to make necessary changes in your structure, process, and outcomes.

DHS is involved in the development of self-assessment modules for planning councils and consortia. These modules are designed to be used by grantees, planning councils, and consortia to evaluate performance with respect to seven legislatively mandated functions and program responsibilities (See box to the right). The modules are designed to be:

- Sensitive to limited resources, both time and financial;
- Cost effective for assessing both performance and outcomes;
- Usable in diverse communities; and
- Appropriate as stand-alone modules to be selected and used based on local evaluation needs and priorities.

SELF-ASSESSMENT MODULES

- Mission and purpose
- Representation and diversity
- Needs assessment
- Comprehensive planning
- Priority setting
- Availability and accessibility of care
- Continuum of care

Each module will contain information to guide its use, including:

- Purpose
- Who should use it
- Activities
- Time required
- Cost
- How to complete it

Each module will include a series of questions, each with measures to look for and potential data sources. Benchmarks against which planning councils and consortia can measure themselves will also be provided, along with some scoring mechanism and guidance on how to analyze results. A description of statistical methods will be provided as needed.

The box on the following page provides a concrete example of how to evaluate performance related to a specific issue, representation and diversity.

A SELF-EVALUATION EXAMPLE

Question	How diverse is the planning council or consortium with respect to race and ethnicity?
Measure	Representation of racial or ethnic groups and populations most affected by HIV/AIDS among the membership of the planning body
Data sources	• HIV/AIDS case reports and other epidemiological data indicating HIV/AIDS cases by race and ethnicity • Planning body membership records
Method of analysis	Compare percent of area HIV/AIDS cases for particular racial and ethnic groups with percent of planning body members who are of these racial and ethnic groups
Benchmarks	Develop locally based on materials such as CARE Act guidance, HRSA policies or draft policies on membership, information in the HRSA report on communities of color, or a preliminary program report from DHS
Related Issues	• Should we consider representation by an agency as opposed to an individual, in terms of an agency's client population? • Should we also consider non-members who are significantly involved in the work of the planning body through committees or work groups?

B. WHO SHOULD DO THE EVALUATION

DHS believes that the entity with primary responsibility for developing the continuum of care should take the lead in evaluation. However, evaluation is usually best done as a collaborative effort. A Title I effort might include the planning council, grantee, perhaps external consultants, and contacts with consumers and providers. A Title II effort might include the consortium, perhaps in combination with the state, perhaps external consultants, and contacts with providers and consumers. Who should be involved in a specific evaluation effort depends partly upon whether the evaluation focuses on structure or organizational issues, process, or outcomes. Evaluation needs to be done by people who are knowledgeable about the topics and can be objective in collecting and analyzing information.

An evaluation committee can be structured in many ways. It might include only members, members and non-members, or only non-members. An outside consultant could take major responsibility for doing the evaluation, with committee or planning body oversight. Graduate students at local universities might serve as an evaluation team as part of their academic work or through a special project involving payment.

C. ATTAINING COLLABORATION

Effective evaluation and quality assurance activities require the involvement of all the agencies and individuals involved in a consortium or planning council. The more active and effective the planning body, the more likely it is to collaborate on evaluation. The box identifies seven keys to successful collaboration.

SEVEN KEYS TO SUCCESSFUL COLLABORATION

1. Shared vision
2. Skilled leadership
3. Orientation to the process
4. Cultural diversity
5. Membership-driven agenda
6. Involvement of multiple sectors
7. Accountability

IV. EVALUATION OF FUNDED PROVIDER PERFORMANCE

A. WAYS TO EVALUATE PROVIDER PERFORMANCE

Evaluation of provider performance should always be done "relative to their contract." Quality of care standards for providers must be contractual to be enforceable, so they should be included in the Requests for Proposal (RFP) process and in contract negotiations and contract documents. Important components of provider performance evaluation include standards, scope of work, methodology, and tools.

In Solano, County, California, the Title II consortium used three steps in developing a process for service provider evaluation -- a process similar to that suggested in the previous section for internal planning body evaluation:

1. **Develop "yardsticks":** Decide what you expect from service providers. Involve providers, clients, and their families in developing goals or expectations. Typically, there is broad agreement about what clients can expect from services, and this foundation of agreement is very useful in developing an evaluation plan. Following are some examples of non-clinical expectations:

- Services should be accessible to eligible clients;
- Services should be client-centered and client-driven;
- Services should be culturally competent.

Clinical issues are also appropriately considered in evaluating provider performance.

2. **Develop indicators:** Decide what criteria or standards you will use to indicate whether a provider is meeting each expectation. These indicators need to be specific and measurable. For example, for the cultural competency expectation, indicators might be that:

   - Staff training on diversity is provided (specify what it should contain, duration, and frequency);
   - Staff reflect the client population in ethnicity and culture;
   - A client satisfaction survey with questions about language and culture is used regularly, and results are positive (specify what level of positive response is expected).

3. **Determine methods:** Decide what approaches you will use to check these indicators. For example, you might use site visits, staff interviews, other provider interviews, and/or client data available from provider records. For the cultural competency expectation and the staff training indicator, you might do the following to check on whether your provider is fulfilling its obligations regarding staff training:

   - Check personnel records to see if staff training is documented;
   - Interview staff and ask them about what training they have received;
   - Review training materials or reports if available.

B. SPECIAL CONCERNS

Special challenges and concerns complicate provider evaluation focusing on rural areas or small agencies. Client confidentiality is a special concern in provider evaluation, as is cultural sensitivity, and these may apply in special ways in rural areas and small agencies.

Conducting service provider evaluation in rural areas can be particularly challenging. North Carolina's experience provides an example. There is sometimes very little leverage available to the grantee because there may be only one service provider in the area or very little choice between providers. The grantee or planning body should avoid designing evaluation efforts to be punitive; it may need to be especially careful not to alienate providers in the evaluation process, and to work with them to develop strategies for improving their performance. The planning council or consortium may want to develop a technical assistance plan for quality improvement. Some agencies may even need to be encouraged or coaxed to meet their contract obligations through incentives, perhaps even financial incentives, for making progress towards meeting these obligations.

Similar issues may arise in the evaluation of small agencies with limited capacity, infrastructure, and resources. Such agencies may lack traditional standards of management or service delivery, yet provide important, culturally sensitive services. For such agencies, it can be useful to develop individualized agency performance criteria which reflect the agency's stage of development and its particular service delivery focus. For example, many agencies have developed around serving particular populations, and performance criteria should reflect this fact. As in rural areas, technical assistance in the evaluation process is of critical importance; planning councils and consortia can develop technical assistance plans based on evaluation results and help in the implementation of those plans.

Client confidentiality can be of particular concern in rural areas, where "everyone seems to know everybody else." North Carolina's experience suggests the value of "partnering," through which two agencies from neighboring counties can conduct the evaluation on each other's files. Another option is to remove client identifying information from files before the evaluation is done.

Specific indicators of cultural competency should be included in provider evaluation. It is not always necessary or possible for someone of the same culture to provide the service, especially in rural areas and small agencies, but indicators should determine whether providers are at least incorporating the cultural values of particular client populations into service provision.

C. WHO SHOULD DO THE EVALUATION

The process of deciding who should conduct provider evaluation is important and requires considerable care. Evaluators need to possess special qualities, as listed in the box. Ensuring unbiased evaluators may

QUALITIES TO SEEK IN EVALUATORS

- Demonstrated integrity
- Knowledge of HIV services and issues
- Cultural diversity
- Lack of bias

require going outside the planning council or consortium membership and beyond your typical work group to create an evaluation team. Staff and board members of other community-based organizations can be identified, or individuals from a neighboring consortium or planning council. The Solano County Title II consortium in California uses some local professionals with considerable expertise and no bias.

Consultation with providers may be important to ensure that the team is trusted by the providers they will evaluate. Confidentiality can also be very important, and it is essential that evaluators understand and be able to deal with this issue.

V. SERVICE PROVIDER QUALITY IMPROVEMENT ACTIVITIES

A. PURPOSES OF A QUALITY IMPROVEMENT PROGRAM

Health care providers and professionals have a responsibility to evaluate themselves. Recently, that responsibility has been extended to include client and community input. HIV/AIDS providers are asked whether they are making good use of the funds provided and whether they are in fact improving the health status or quality of life of people with HIV disease and their families. It is important to be able to show evidence that you are doing a good job.

The purpose of a Quality Improvement Program is to show good stewardship of the funds provided -- to enable providers to answer the following questions affirmatively:

- Are we doing the right things for our clients?
- Are we doing those "right things" well?
- Are we achieving the therapeutic goals or outcomes that we want?

Quality improvement is best viewed as "a journey rather than a destination." If the philosophy is one of continuous quality improvement, the cycle is ongoing. Moreover, some quality improvement issues will take a long time to resolve. It is important to carry out quality improvement activities on a regularly scheduled basis; annual or semi-annual reporting helps focus on what has been done.

B. SETTING STANDARDS OF CARE

There is no clear answer to the question of who should set standards of care. The appropriate body depends to some extent on whether the standards are clinical or programmatic. Grantee-level involvement can be based upon work with committees whose members may include external quality improvement experts, clinicians, representatives of service providers, consumers, and other individuals. The case studies which follow illustrate several models for developing clinical and case management standards. The box lists clinical guidelines published by the federal government which are of direct importance to HIV/AIDS service providers.

CLINICAL GUIDELINES PUBLISHED BY THE FEDERAL GOVERNMENT

- Pediatric and adult PCP prophylaxis
- Prophylaxis for other opportunistic infections
- Anti-retroviral treatment for infants and reduction of perinatal transmission
- Early HIV disease management
- Prophylaxis for TB-HIV co-infection

While many clinical guidelines are developed at the federal level, HRSA believes in flexibility at the state and local levels. Many health care providers tend to see these standards of care as "cookbook medicine" and as imposed from above. It is very important that the final standards or practice guidelines be developed or refined locally, using all available resources.

In developing standards of care, it is important to review and make reference to the scientific basis upon which those standards are based. Otherwise, there is always a danger of institutionalizing poor practice into a standard of care.

The basic process of setting standards of care is similar whether the standards involve clinical care or social support services. It involves thinking about what is needed, and what the process issues are as well as desired outcomes. The process of developing and using standards is a logical one: define how you think you ought to do things, then do them, and then see if you have done them. The "mindset" is important: you are looking at the services you provide not in a punitive sense but from the perspective of how to improve them. Involving clients in the process is also very important.

C. CASE STUDY: A CLINICAL CARE QUALITY IMPROVEMENT PROGRAM

The AIDS Institute of the New York State Department of Health manages a Quality Improvement Program which focuses specifically on clinical care. The AIDS Institute coordinates AIDS programs and administers the Title II program. It has always had the authority

for monitoring quality of HIV medical care, including Medicaid providers and CARE Act providers. Its Quality Improvement Program combines external and internal review and uses the principles of continuous quality improvement instead of the more "heavy-handed" inspection model. Major features of the overall program and the External Review Program include the following:

- **The program is based on clinical practice guidelines,** developed through collaboration with a group of HIV clinical providers.

- **Priorities are established for review.** A group of providers identified what they considered the most important aspects of care for review.

- **Ongoing collaboration with providers occurs through a statewide Quality of Care Advisory Committee.** This committee grew out of the group of providers consulted in the development of clinical practice guidelines and priorities for review.

- **The program uses a very specific External Review Program involving the review of medical records.** Under contract, the Peer Review Organization in New York uses a specially trained HIV Unit to review a sample of records at nearly 200 facilities.

- **Providers receive aggregate data from the record reviews,** and no penalties are attached to this information.

- **The data make possible comparisons of performance among providers and determination of changes in an individual provider's performance over time.**

- **Each provider seeks, through internal review, to improve care.** The External Review Program makes it possible to validate the internal reviews.

- **The program provides public accountability** concerning how money is being spent.

- **The review allows for practitioner variation and individual judgment.** There is a built-in feature that allows an individual to document when s/he is pursuing a different approach than the usual clinical standard of care.

New York State encourages its clinical service providers to incorporate their external review data into their own ongoing Internal Quality Improvement Programs. The external reviews are intended as additional information for clinicians and not as a replacement for internal quality improvement activities. The External Review Program provides a powerful

stimulus to providers to set up Internal Quality Improvement Programs, where real change and quality improvement happen.

A major concern is how to create improvements and sustain them over time. Approaches which contribute to this goal include the following:

- Establishment of multidisciplinary teams for specific projects.
- Recognition that problems often have multiple causes, and cannot be solved through "quick fix" solutions.
- A focus on solving problems by changing the system, rather than blaming individuals.
- An emphasis on ensuring management's commitment and support, and ensuring that the information reaches both administrative personnel and patient-level staff.
- Use of quality consultants to assist facilities with their internal programs; assistance ranges from a telephone call to regular on-site services such as team facilitation or assistance with a specific project.

The program has found that this approach to quality works well with organizations ranging from small community-based groups to large teaching hospitals, because accountability is focused on the entire organization rather than one individual. The tools and techniques used in quality improvement are easily understood by both clinicians and non-clinicians. The real challenge is in maintaining an ongoing, fluid process that is internally driven and is able to achieve and maintain improvements.

While the program is based on clinical care, the AIDS Institute encourages providers not to limit themselves to clinical quality issues. Patients do not necessarily define quality in the same way as a clinician.

In looking at data over the past two-and-one-half years, the AIDS Institute has been able to document change over time, and has seen overall improvement. Since so many facilities are reviewed, there is considerable variation. The State tries to target for assistance those facilities that do not show any improvement.

D. CASE STUDIES: CASE MANAGEMENT QUALITY IMPROVEMENT PROGRAMS

1. Orange County, California

The Orange County HIV Community Services Program planning body mandates that all HIV service providers have a Quality Improvement Plan. This plan addresses quality issues related to provider contracts. In addition, each agency is contractually required to have a representative on the planning body's Quality Improvement Committee. For example, the AIDS Services Foundation, Orange County's primary nurse case management agency has a Quality Improvement Plan developed by an internal Quality Improvement Committee of staff, Board members, and clients. It is responsible for establishing specific indicators for standards of care and procedures for measuring performance (See box), and for carrying out case management audits using these standards.

AN EXAMPLE OF HOW QUALITY OF CARE IS DETERMINED IN ORANGE COUNTY

Goal	A client's needs and requests will be responded to in a timely manner.
One related objective	Newly referred clients will be contacted within one working day.
Minimum acceptable standard	90% of clients will be seen within one working day.
Method of measuring performance	Random review of 10% of pre-registration forms each quarter to determine staff response time.

Case management audits are conducted by agency staff not directly associated with case management. Confidentiality is not a major issue since reports contain only client initials or numbers and are prepared by agency staff. Audit results are prepared in writing for the agency's own internal committee and the Planning Council's Quality Improvement Committee.

The Quality Improvement Committee was established to develop policies and procedures for all County-funded HIV service providers, not to micro-manage any agency. Providers are contracted because of their expertise in providing specific services, and given leeway to provide those services to the best of their ability. Quality improvement offers an opportunity for providers to use both their own and other providers' expertise in delivering services.

The quality improvement process is not punitive; it is a collaborative community technical assistance process that benefits the provider and ultimately the client. It also helps minimize common mistakes and problems associated with new service providers. The internal quality improvement structure is established by each provider, and the external structure is established by the Quality Improvement Committee, made up of other providers. Standards are set by providers with assistance from their peers, and the peers review and approve these plans.

Once a plan is approved, implementation using the measures is objective. Providers submit to the Quality Improvement Committee quarterly progress reports on their outcomes and the progress of their plans. They report any possible factors which have kept them from meeting standards and propose a corrective plan. The Quality Improvement Committee reviews the plan and acts as a technical advisor, helping to determine if other factors could be impeding progress with the plan and sometimes offering other suggestions for correction action.

2. North Carolina

North Carolina sees case management as the access point for all other CARE Act services, and considers it extremely important to assure that case management services are comprehensive and high quality. The AIDS Care Branch of the Department of Health therefore developed clear standards for case management service delivery and implemented them statewide to cover all agencies receiving CARE Act funding as well as a recently initiated Medicaid HIV Case Management Program. The standards were developed in collaboration with consortium representatives, providers, and clients. The assessment process was turned over to consortia for implementation with their service providers, with case reviews conducted collaboratively by representatives of the consortium and the providers.

The Quality Assurance Peer Review process used in North Carolina is designed to provide service providers the opportunity to evaluate the quality of case management being provided, identify problems, recommend solutions, and develop strategies for strengthening their case management system. Chart reviews are conducted annually by Peer Review teams, which complete a ten-page HIV Case Management Chart Review tool, which includes an HIV Case Management Standards Checklist and Annual Report. Each consortium is required to conduct chart reviews on a minimum of 10% of active client records plus three discharged charts for its consortium region. Confidentiality is ensured by removing all client identifying information from the charts and also bringing in some outsiders to help agency staff conduct chart reviews. To be in compliance with the case management practice standards required by the AIDS Care Branch, each chart must receive a disposition score of 70% based on the chart reviews.

Once the reviews are completed, a plan for improvement is developed to address identified issues of concern. The information is shared with the full consortium and the AIDS Care Branch. It also feeds back into the Branch's Training Plan for case management, so that statewide training can be provided to address problem areas found in multiple locations.

E. RESOURCES

DHS offers the following resources for evaluation and quality improvement:

Technical assistance: Grantees which need help in implementing service provider Quality Improvement Programs can request peer-based technical assistance through their Project

Officer at DHS. Peer external consultants can be made available to respond to individual requests. Other evaluation-related assistance is also available.

Models: The HRSA Quality Improvement Project will lead to additional information about examples and models of quality improvement activities in the social service arena.

VI. CONCLUSIONS AND EVALUATION

A. CONCLUSIONS

Evaluation and quality improvement are extremely important topics. The teleconference call provided a broad overview of approaches for ensuring accountability and assessing and continuously improving the quality of care in HIV-related service delivery.

HRSA views this broad discussion as an opportunity to contribute to a long-term collaborative process. The continuing participation of planning councils and consortia, grantees, providers, clients, and other community representatives is necessary to help identify and take additional steps towards the goal of assuring high quality care for people living with HIV disease and AIDS throughout the country.

B. EVALUATION

Participants in each teleconference call are encouraged to complete brief written forms asking for evaluation feedback, suggestions/comments, and recommendations for follow-up. the national CARE Act technical assistance provider for analysis. Forty-one evaluations were received for this teleconference call; the full evaluation report is included as Appendix E. Major results are summarized below.

- **Overall, respondents agreed that this conference call was extremely useful,** with well-organized speakers presenting helpful information. They found speakers easy to hear and understand.

- **Nearly all respondents strongly urged prompt written follow-up,** including this written report and sample evaluation materials. Due to the speed of the speakers and the breadth of information presented, many respondents feel this call cannot be considered effective without a written report.

- **Listeners would like to receive copies of the quality improvement materials and forms** mentioned by panelists during the call (See Appendix D).

- **Respondents would like a speakers list with telephone numbers** so they can contact panelists for further information (See Appendix A).

- **Some respondents feel that calls should focus on narrower topics**, to allow for a more in-depth discussion.

- **Some respondents would like to see smaller teleconference calls,** arranged by region or by type of participant -- such as Title II-only states versus Title I-II

states, urban versus rural areas, etc. -- so that the information can be targeted to specific audiences.

APPENDIX A:
PANELISTS

FACILITATOR

Jon Nelson, Chief, Planning and Technical Assistance Branch, Division of HIV Services

PANELISTS

Anita Eichler, Director, Division of HIV Services

Steven Young, Chief, Eastern Services Branch and Acting Chief, Western Services Branch, Division of HIV Services

Donna Yutzy, Technical Assistance Consultant to the Division of HIV Services, Sacramento, California

Don Widmann, Consultant and Former Director, Department of Standards, Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

Marcia Manley-Anderson, Consultant and Member, Title II Ryan White Care Consortium of Solano County, California

Carolyn Harley, Head of the AIDS Care Branch, North Carolina Department of Health, Raleigh

Dr. Bruce Agins, Acting Medical Director, New York AIDS Institute, New York State Department of Health

Margaret Palumbo, HIV Quality of Care Specialist, New York AIDS Institute, New York State Department of Health

Mitch Cherness, Program Supervisor, Title I Orange County HIV Community Services Program, Orange County, California

APPENDIX B
AGENDA

I. Welcome and Introductions

II. HRSA'S Expectations Regarding Quality Improvement

III. New Requirements in the Proposed Reauthorization Legislation

IV. Internal Evaluation of Planning Councils and Consortia

V. Evaluation of Funded Provider Performance

VI. Quality Improvement for Service Providers: Improving Client Care

VII. Closing Comments

APPENDIX C:
SUGGESTED READINGS

Bozzette, S.A., and S. Asch, "Developing Quality Review Criteria from Standards of Care for HIV Disease," *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology,* 1995; 8 (Supplement 1): S45-S52.

El-Sadr W., J.M. Oleske, B.D. Agins, et al., *Evaluation and Management of Early HIV Infection: Clinical Practice Guideline No. 7.* AHCPR Publication No. 94-0572. Rockville, Maryland: Agency for Health Care Policy and Research, U.S. Department of Health and Human Services, January 1994. (Single copies available at no cost. Call CDC AIDS Hotline at 1-800-342-AIDS.)

Wilson, I.B., "Quality of Care and HIV Infection: Theory and Practice," *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology,* 1995; 8 (Supplement 1): S31-S44.

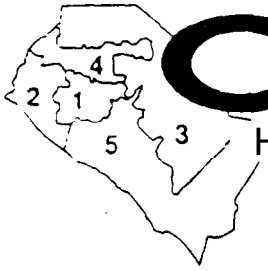
Using Clinical Practice Guidelines to Evaluate Quality of Care: Volume 1, Issues; Volume 2, Methods, AHCPR Publication Nos. 95-0045, 95-0046. Rockville, Maryland: Agency for Health Care Policy and Research, U.S. Department of Health and Human Services, March 1995. (Single copies available at no cost. Call AHCPR Publications Clearinghouse at 1-800-358-9295.)

APPENDIX D:
ORANGE COUNTY QUALITY IMPROVEMENT TECHNICAL ASSISTANCE PACKET

Attached are the following materials from the Orange County, California HIV Planning Advisory Council:

- The Quality Improvement Technical Assistance Packet prepared for contracted service providers

- Policies and procedures that guide the peer-based Quality Improvement Committee



COUNTY OF ORANGE

HEALTH CARE AGENCY

TOM URAM
DIRECTOR

HUGH F. STALLWORTH, M.D.
HEALTH OFFICER

1719 WEST 17TH STREET
SANTA ANA, CA 92706

TELEPHONE: 714/834-8025
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SANTA ANA, CA 92706

PUBLIC HEALTH

Date: August 30. 1994

To: All Quality Improvement Committee Members

From : Michele Quintana

Subject: Quality Improvement Plans

Attached find a brief summary of what well written Quality Improvement plans should contain. I have spent several hours reviewing your submitted Q. I. plans and most of you seem to have adequate plans. Remember each of your plans are to be program specific and may vary according to the program/services you supply.

One area where the plans may be lacking is in describing how you will evaluate your services. Some time should be spent in developing a tool or tools which would evaluate the quality of services provided.

Some suggestions for evaluations tools are:

1. client /employee suggestion box;
2. Specialized client post services/treatment questionnaire:
3. client follow-up interviews;
4. hacking of services received by client; and.
5. chart/file review .

Please take a few moments to see if your plans contain the information spelled out on Attachment I. If not, please revise your plan to include this information. Also, please take a few minutes to try and produce an evaluation tool which is program specific. Attachment II is a sample of an evaluative questionnaire which may act as a starting point for those who are having trouble coming up with ideas for evaluative tools. By taking this time now, rather than when Imeet with you, it will expedite the review process.

Thank you for your cooperation, if you have any questions please feel free to contact me at 834-8063.

Attachment I

QUALITY IMPROVEMENT PLANS

The following is a brief overview of what Quality Improvement plans should contain. This is by no means the only way in which plans can be drawn up, however these are common areas which all well written plans should cover.

All plans should have a mission statement. This statement will help define the reason for the establishment of a Quality Improvement Plan/Program.

EXAMPLE:

> The Quality Improvement Plan is designed to monitor, evaluate, and improve client services and the programs of the AIDS Coordination Program. The Quality Improvement Program will ensure optimal provision of client services and programs.

All plans should contain goak. These goals will state what the Quality Improvement plan seeks to accomplish.

EXAMPLE:

> Quality Improvement refers to activities and programs designed to evaluate client care. These activities will identify, study, correct, and document known or suspected problems in, or opportunities to improve client care. Monitoring will be conducted by:
>
> - Activities developed to access specific areas of client services which are high volume, high risk, or problematic on an ongoing basis.
> - Concurrent and retrospective studies of client files.
> - Cost Benefit analysis.
> - Contract compliance.

All plans should have objectives. These objectives should indicate what Quality Improvement seeks to accomplish.

EXAMPLE:

The objectives of the our Quality Improvement Plan are:

* To maintain and improve delivery of quality care through the identification of problem areas where improvement is needed.

* To promote efficient use of community and private resources and to strengthen through the regular monitoring of all aspects of care/ services provided.

* To provide assistance and guidance to staff in the identification of problems or opportunities for improvement

* To improve employee satisfaction through their participation in improving delivery of client services.

* To provide an opportunity for client input to improve client services.

Finally, all plans should have a mechanism by which the plan can be implemented. This mechanism can take the form of either a Board or a Committee.

EXAMPLE:

The Quality Improvement Committee will have overall responsibility for the design, implementation and monitoring of the Quality Improvement Program and it's activities. The Executive Committee of AIDS Coordination will serve as the Quality Improvement Committee.

Attachment II

July 6, 1994

AIDS RESPONSE PROGRAM/THE CENTER OC
QUALITY IMPROVEMENT MONITOR

RWCA TITLE I PROGRAMS: Benefits Counseling
Mental Health Services
Access to Services to Men of Color

RWCA TITLE Ii PROGRAMS: Being Alive
Enhance (effective 7/1/94)

REVIEW: This quality improvement report will focus exclusively on the AIDS Response Program's (ARP) Benefits Counseling. We will address the Q.I. issues of Mental Health Services, Access to Services to Men of Color and Being Alive in future reports.

PURPOSE: To assess ARP's Benefits Counseling's quality of service to clients and contractual compliance.

CRITERIA: The information provided is based on clients served in the previous three (3) months and on the following criteria:

1. How many clients were served in the previous three months?
2. Was a group evaluation tool created, and if so, has it been effectively distributed?
3. Was a client intake form completed for each client receiving services?
4. What type of filing system has been created to document any referrals and is there a plan for follow up with the client?
5. How often do we follow up with clients and what is the rate of success in contacting them?
6. Has an individual client survey been created, and,if so, has it been effectively distributed?
7. What is the rate of return of all surveys distributed?
8. What is the level of satisfaction with services provided?

SAMPLING METHODOLOGY: All clients seen at the ARP office or at an off-site location (Orange County Health Care Agency, Laguna Shanti, home visits, group presentation, etc.) were sampled by way of a client survey. All clients surveyed were required to complete .a Client Intake Form. This intake form includes name, address, phone numbers, ethnicity, medical information (physician name and phone number), work information, health insurance coverage information and any pertinent information regarding this particular client. The ARP Benefits Counselor is responsible for monitoring all of the records of clients seen for benefits counseling purposes and any referrals made, whether internally (mental health services, etc.) or to other agencies for needed services.

All clients receive a follow up telephone call within 60-90 days of the initial intake/benefits counseling appointment. If the client can not be reached via telephone, a letter is sent to the client in an attempt to contact them.

In total 35 individual client surveys were distributed via mail To date 24 surveys have been returned. The surveys were reviewed to evaluate the criteria listed above.

FINDINGS AND RECOMMENDATIONS: Benefits Counseling does not require or request a consent form to release information, as NO information is given out to other agencies, physicians, insurance companies, etc. at any time, and all records are coded and kept in the strictest of confidence. Referrals are done at client's reauest onlv. If the Benefits Counselor intercedes on behalf of a client regarding insurance matters, the client's name is never released and often times the Counselor will use hypothetical situations in order to protect the anonymity of the client and their situation.

Of the individual surveys returned as of June 28, 1994 the median age is 34. Of the 24 surveys returned, 23 were male clients and 1 was female. Other statistical information is shown below.

-Clients served not aware of the quality of service until appointment.	76%
-Clients served receiving services beyond their expectations.	96%
-Clients saying they would call for more information and/or assistance.	98%
-Clients who would recommend this service to others.	98%
-Clients confidence in the Benefits Counselors knowledge and ability.	94%
-Clients response to the quality and usefulness of the Benefits Guide.	93%
-Clients general satisfaction with quality and service provided by the Benefits Counselor.	92%

A group presentation survey has recently been designed and will be used at ALL group presentations from this date forward. This will allow ARP to track the effectiveness and quality of service in a group setting.

Whenever a client is referred to another agency for services (ASF, HCA, OCCH, Shanti, etc.), this information is noted in the client file so that continuity and quality of care can be maintained.

RECOMMMENDATIONS: This Quality Improvement Monitor is to be presented at the next quarterly meeting of the ARP Advisory Board (who is also the QI Committee for ARP). The Benefits Counseling Program will be subject to review in 6 months to assess the above criteria for improvement and/or to maintain the current strategies in delivering this program.

At the present time, according to the contractual agreement, the number of clients receiving services are those who are seen one-on-one by the Benefits Counselor or in a group presentation. These formats do not allow for telephone contacts to be included in the statistical reports. It is recommended that telephone interviews be allowed to be included in such reports, as there are

clients who insist on maintainrng their anonymity and would not come to ARP/The Center for Benefits Counseling. Therefore, the telephone is the only acceptable means of communicating with the Benefits Counselor for clients who wish to remain anonymous.

The next Quality Improvement report will reflect the other ARP RWCA funded programs.

ATTACHED: Client Intake Form
Individual Survey Form
Group Survey Form

Client Intake Form

Name: Contact Date: Intake Date:

Birthdate: Sex: M F Sexual Orientation: · Risk Factor:

Address:

City: Zip Code:

Home Phone: ( ) Work Phone: ( )

Leave Message?: YES NO Be Discreet? YES NO

Race / Ethnicity: Mailing List:

Medical Information

Physician: Phone Number: ( )

Physician: Phone Number: ( )

Work Information

Employer:

Insurance Available: Medical Dental Life Disability Vision None

Health Coverage Information:

Health Insurance Co.:

Type of coverage: Deductible?:

Cost of premium: COBRA available?:

Medi-Cal: YES NO MSI: YES NO Medicare: YES NO

Notes:

Group Evaluation

EVALUATION OF PRESENTER

AGE: SEX: M F DATE:

1. Organization of presentation

Very Good 5 4 Average 3 2 Poor 1

2. Knowledge of presenter

Very Good 5 4 Average 3 2 Poor 1

3. Quality of printed material

Very Good 5 4 Average 3 2 Poor 1

4. Overall quality of presentation

Very Good 5 4 Average 3 2 Poor 1

5. I would call for a question or an appointment. YES NO

6. If you answered NO to question 5, why not?

7. What can be done to improve the quality of the presentation?

Thanks for your input.

Evaluation of Benefits Counseling

Age: Sex: M F Date:

1. Did you know what to expect when you made your appointment for benefits counseling? Yes **N o**

2. Did your benefits counseling session meet your expectations? Yes No

3. The Knowledge of Benefits Counselor

Very Good		Average		Poor
5	4	3	2	1

4. The Quality of the Printed Benefits Guide

Very Good		Average		Poor
5	4	3	2	1

5. I would call again if I had more questions. True False

6. If you answered false to question 5, why not?

7. Would you recommend this program to others? Yes N o

8. Overall Quality of the Benefits Counseling Program.

Very Good		Average		Poor
5	4	3	2	1

9. What can we do to improve this program?

THANK YOU FOR YOUR PARTICIPATION

QUALITY IMPROVEMENT COMMITTEE
EVALUATION FORM

AGENCY:

SERVICES FUNDED:

FUNDING PERIOD:

REPORTING PERIOD:

EVALUATION:

1.	Did agency submit last quarter's Service and Staffiig Reports? (County Agencies will use Quarterly Statistical Data)	Y	N
2.	Did Agency's QI Report reflect one or more funded services?	Y	N
3.	Does the sample reflect criteria identified in the Agency's QI plan?	Y	N
4.	Was sample number adequate? (at least 10% of client population or no more than 30 charts/files)	Y	N
5.	Did sample meet established percentage of compliance?	Y	N
6.	If not, did agency make recommendations to implement change?	Y	N
7.	Are recommendations acceptable?	Y	N
8.	Did agency establish date to resubmit areas of report not meeting compliance?	Y	N

COMMENTS:

ORANGE COUNTY HIV PLANNING ADVISORY COUNCIL
Policies and Procedures

Subject:	Quality Improvement Committee Meetings/Actions	Number: III.E Date Effective: September 14, 1994 Page: 1 of 1

1.0 PURPOSE: The purpose of this policy/procedure is to establish policy relative to meeting day, time. attendance, proceedings. and rules of government not otherwise stated in the bylaws.

2.0 MEMBERSHIP: Providers under the Ryan White CARE Act will designate an individual to serve as the Agency's Quality Improvement Coordinator. The Quality Improvement Coordinators, or their designees and an HIV Community Services staff member shall constitute the membership of the Quality Improvement Committee.

3.0 MEETING. TIME, PLACE, DATE: The Committee will meet every 4th Wednesday of the month or as needed. at 10:30 a.m., at the Horton Bldg.. Suite #301, in Santa Ana, California.

4.0 ATTENDANCE: Attendance at meetings is mandatory. Either the Quality Improvement Coordinator and /or his/her designee must attend the regularly scheduled meetings.

5.0 VOTING

5.1 While the Committee will strive for consensus, every official action of the Committee shall be adopted by a simple majority of the voting members present A roll call vote shall be taken when requested by any member in attendance.

5.2 A quorum of the Committee must be present at any regular or special meeting in order for a formal decision to be made on any matter. A quorum shall consist of a simple majority of all Committee members.

5.3 Members will not involve themselves in official Committee actions which could materially benefit them personally, their business interest, or the interests of organizations they represent. In a matter of a conflict of interest, the member will abstain from voting and the abstention shall be recorded in the minutes.

5.4 Only committee members or their designees may vote.

ORANGE COUNTY HIV PLANNING ADVISORY COUNCIL
Policies and Procedures

Subject:	Quality Improvement Review for HIV Service Providers	Number: III.E.1 Date Effective: September 14, 1994 Page: 1 of 3

1.0 PURPOSE: The purpose of the procedure is to ensure the evaluation. maintenance, and improvement of the quality of client care. This policy/ procedure will describe the quality assurance review process for the Ryan White Title I and II Act providers. as well as, for any other providers, who are funded from ocher HIV sources, for which the Council has agreed to provide assistance through the Quality Improvement Committee.

2.0 **REQUIREMENTS :**

2.1 Providers under the Ryan White CARE Act will submit to the Quality Improvement Committee an annual Quality Improvement Plan (QIP). This plan will set forth specific program objectives and or stated contractual agreements. The QIP is to be submitted to the HIV Community Services staff no later than 30 days from the date of the execution of a contract and/or the start of services.

2.1.1 The QIP will specify qualitative and quantitative reports used to measure the projected plan's objectives and /or contractual objectives.

2.1.2 All providers will designate an individual to serve as the Agency's Quality Improvement Coordinator.

2.1.3 The Quality Improvement Coordinator, or his/her designee. is required to attend the Quality Improvement Committee meeting on a regular basis.

2.1.4 All defined services will be consistent with the CARE Act and the working definitions approved by the HIV Planning Advisory Council.

2.1.5 Agencies will be monitored and evaluated to determine the program's comprehensiveness. effectiveness, cost efficiency, and integration with other programs within the agency.

3.0 FUNCTION:

3.1 An annual review may be conducted by a review team. whose members are designated by the Quality Improvement Committee.

3.1.1 A staff person from the HIV Community Services Unit will serve as the team coordinator. The team will be made up of members of the Quality Improvement Committee, which are members of other HIV service organizations (peers), and possibly other service providers from the private and public sectors in and outside of Orange County. No team member shall review their own agency.

3.1.2 Cultural, and gender sensitivity and appropriateness will be observed in the selection of the membership of the review team.

4.0 REVIEW METHOD/ASSISTANCE:

4.1 Review methods may include confidential records review. interviews with staff, clients, and volunteers. Due to the sensitivity of the materials reviewed. members of the review team will be asked to sign a Statement of Confidentiality. This statement will indicate that the team member will hold all client information confidential, except in those circumstances in which authorization has been given by the client in writing. The Statement of Confidentiality will apply to all personal, social, and medical information gathered for Quality Improvement Activities.

4.2 The review team may assist providers to refine their internal quality assurance process. The team may help providers establish methods for improvement of their services. These methods of improvement may include. but are not limited to, technical assistance, onsite visits, policy and procedure review, review of charring and notation procedures, as well as coordination of referrals.

4.3 Providers may request the assistance of the review team to develop tools/ methods for the ongoing monitoring of service activities. These tools/methods should be sensitive to the populations served.

5.0 APPEALS PROCEDURE

5.1 Persons or agencies must submit in writing an appeal request specifying the reason for an appeal. Available supporting documentation regarding the complaint must accompany the appeal.

5.2 The appeal and facts for review will be heard by the Executive Committee of the HIV Planning Advisory Council and a staff person from HIV Community Services. Said findings will be presented to the Quality Improvement Committee.

5.3 The Quality Improvement Committee Chair shall notify the appellant in writing within ten (10), working days after a decision has been made on the appeal.

APPENDIX E:
SUMMARY OF PARTICIPANT EVALUATIONS

RYAN WHITE TECHNICAL ASSISTANCE CONFERENCE CALL

"Quality Assurance and Improvement"
August 3, 1995

SUMMARY OF PARTICIPANT EVALUATIONS

On August 3rd, 1995, 146 sites listened to the sixth in a series of technical assistance conference calls, sponsored by the Division of HIV Services. Audience members represented over 700 Title I and II grantees, Planning Councils, Consortia, AETC's, and provider agencies. Ten panelists answered questions submitted by registrants on the topic of Quality Assurance and Improvement. Contributing speakers consisted of the following:

* Bruce Agins, M.D., M.P.H., Acting Medical Director, NY Dept. of Health, AIDS Institute
* Mitch Chemess, Program Supervisor, County of Orange HIV Community Services
* Carolyn Harley, Head, AIDS Care Branch, North Carolina Dept. of Health
* Marcia Manley-Anderson, Consultant and Member, Ryan White Care Consortium of Solano County
* Margaret Palumbo, HIV Quality of Care Specialist, NY Dept. of Health, AIDS Institute
* Don Widmann, Consultant
* Donna Yutzy, Consultant

Speakers from the Division of HIV Services consisted of the following:

* Anita Eichler, Director
* Steven Young, Chief, Eastern Services Branch and Acting Chief, Western Services Branch
* Jon Nelson, Chief, Planning and Technical Assistance Branch

Forty-one evaluations were received in the several weeks following the conference call. Overall. respondents agree that this conference call was extremely useful, with well organized speakers presenting helpful information. The conference call went smoothly - speakers were easy to hear and understand. Almost all respondents feel strongly that written follow-up should supplement this presentation.in the form of a written summary and sample materials.

This report is comprised of four main areas, brought forth by the participants' evaluations. They are: 1) suggestions or comments regarding this conference call; 2) recommendations for follow-up to this conference call; 3) recommendations for future conference calls; and *4)* suggested actions for improvement.

Suggestions or Comments Regarding this Conference Call

Several participants feel that the examples used in this conference call were helpful illustrations of Quality Improvement, while others claim that the information presented was still too basic. Better and more detailed program examples could have worked to eliminate broad, general answers to questions, argues one respondent.

Specifically, comments are positive regarding the discussion of the process of developing Quality Improvement measures. Also mentioned in a positive light is the piece on internal evaluation of consortia. Some believe that issues of client confidentiality in remote and rural areas should have been more extensively addressed.

Some listeners applaud organizers for beginning and ending the call on time, and speakers for adhering to time limits within the call.

Throughout their evaluations. respondents instruct the speakers to slow down.

Random comments and suggestions include the following:

* The call provided information on what types of assistance can be expected from HRSA in the area of Quality Improvement.

* The Division of HIV Services needs an organized Quality Improvement program.

* The discussion was not always applicable to those listeners with very limited resources.

* The agenda, facilitation, and speakers' use of lists were all positive aspects of the conference call.

* The presentations should have been better balanced between clinical providers vs. social service providers, large agencies vs. small agencies, and urban vs. rural agencies.

Recommendations for Follow-Up to this Conference Call

Almost all respondents request written follow-up. This becomes especially important for this conference call, where listeners complain throughout the evaluations that they couldn't write fast enough to keep up with the speakers. Written follow-up, they assert, will compensate for this frustration in note-taking. Due to the speed of the speakers and the breadth of information presented, many feel this call can not be considered effective without a written report. Respondents continuously ask that this follow-up be prompt, indicating that one month is too long to wait for this material.

Listeners repeatedly suggest the inclusion of a list of speakers names and telephone numbers in the written follow-up, as well as copies of Quality Improvement materials and forms mentioned by presenters during the call.

Other suggestions include:

* Develop a collection of standards used in EMA's and distribute to all EMA's.

* Coordinate EMA's with working Quality Improvement programs and facilitate the sharing of their information.

* Disseminate a copy of findings from both an internal and an external Quality Improvement process.

* Supply information on the self assessment modules.

* Provide a forum for the exchange of monitoring materials between conference call participants.

* Offer a basic structure for Quality Improvement guidelines.

* Clarify and specify HRSA requirements on this topic

Recommendations for Future Conference Calls

Similar to the evaluations of previous conference calls, comments suggest that the conference call attempted to cover too much ground, and that future calls should focus on more narrow topics to allow for a more in-depth discussion. Again. five or six respondents want smaller conference calls, separated either by region or by audience.

Several feel that the availability of more written information prior to the call would benefit the presentation, as well as encourage participation.

One listener suggests that the facilitator announce at the start of the call that a report will be provided, so that listeners can choose whether or not to take notes.

Actions for Improvement

Throughout the evaluations for each technical assistance conference call. several issues always arise: 1) Nationwide calls on a general topic are not always applicable to everyone, and 2) There needs to be written follow-up provided consistently and in a timely manner.

The **following** are courses of action devised to meet these needs:

1) Smaller Conference Calls Conference calls could be planned and scheduled in a variety of ways to avoid seeming too general. Issues could be discussed separately and geared toward separate audiences. For example. consortia development could be discussed in a call with Title II only states, with a separate call to discuss the same topic among states with Title I and II funds. Calls could also be broken down by region. For example, separation of urban areas and rural areas is often suggested by listeners.

2) Internal Checks on Report Progress The system for conference call report production could be standardized in such a way so as to expedite report dissemination. Those involved would be required to adhere to a schedule, consistent for all conference calls. For example. a first draft can be due two weeks after the receipt of the transcript to DHS, with DHS comments due one week after receipt of the draft. The final draft can be due to DHS and JSI one week later, bringing total production time to approximately one month after the actual call.